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ABSTRACT

This article discusses a program originated in response to the need to serve a most disturbed segment of children in New York City--youngsters discharged from psychiatric hospitals or residential treatment centers. This program directly links separate social institutions--the schools and the mental hospitals--in a plan for unified services to one group of children. The program is defined as a transitional resource intended to prepare these students for long-term placement in regular or special education classes. The goals are to improve social functioning and to provide academic remediation. Although the children are severly disturbed and many of their families are so helpless and disorganized that placement of a large percentage of them is a real consideration, the program has demonstrated that many of these children can attend school regularly, can improve their behaviors dramatically, and can learn. The authors present a description and progress report in order to highlight some of the successes and failures of the program. (Author/PC)

THE TRANSITIONAL CLASSES-A NEW INTER-AGENCY PROGRAM

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The Transitional Classes Program originated in response to the need for a resource to serve a most disturbed segment of children in New York City--youngsters discharged from psychiatric hospitals or residential treatment centers. School and hospital personnel, as well as parents, had expressed serious concern for years about the enormous difficulties facing these severely emotionally handicapped children in school settings. Experience had indicated a high percentage of recidivism; many children were clearly unable to successfully manage an initial regular class placement. The child's right to continuity of education both in hospital and upon discharge was pointed up by the Citizen's Committee for Children of New York.[1] A New York City Board of Education--New York State Department of Mental Hygiene Coordinating Committee was convened with involvement of Citizens Committee in 1970. The scope of this Coordinating Committee was enlarged by representation of the New York City Department of Mental Health & Mental Retardation Services and the New York State Department of Education. This group gave impetus to the drafting of a proposal for the Transitional Classes Program which received Title I funding in 1971. This program directly linked separate social institutions--the public schools and the city and state mental hospitals--in a plan for unified services to one group of children. The overlapping of concern was clear; the hospitals retained responsibility for aftercare of patients and the schools carried

CG 009 174

[1] "Our Children in New York State Psychiatric Hospitals"
Citizens Committee for Children - April 1970

responsibility for providing the education of these children. The proposal outlined a psycho-educational plan which specified a minimal commitment of half day weekly of clinical services from the hospitals to be provided at the school settings which the Board of Education would develop.

The program was defined as a transitional resource intended to prepare these children for long-term placement in regular or special education classes. The goals were to improve social functioning and to provide academic remediation. Transitional Class units have been established since 1972 on a city-wide basis. Each unit is linked to a cooperating hospital. During 1972-73 there were 100 children enrolled in the program at any one time. These numbers have since increased. The children are severely disturbed and many of their families are so helpless and disorganized that placement of a large percentage of the children is a real consideration. With this group the Transitional Classes Program has already demonstrated that many of these children can attend school regularly, can improve dramatically, and can learn.

We are presenting this description and progress report in order to highlight some of our successes--sometimes dramatic--as well as our limitations and failures so that this information may prove useful to others working within this area - namely the rehabilitation of severely mentally and socially ill children.

DESCRIPTION OF UNIT

Perhaps the best way to describe the Transitional Classes Program is by a look at one unit which can be considered descriptive of all, but with

its own special quality. This unit is a joint project between the central Board of Education, the local community school district and Jacobi Hospital of New York. It is located in the South Bronx, an area generally characterized by deserted or crumbling tenements, with an extremely high crime and delinquency rate. Frequent newspaper exposes describe appalling social conditions and poverty.

In the school years of a relatively new elementary school building there is a separate minischool. The outer walls are marked by the typical graffitti; the windows are barred; the doors are locked from the inside during the school day for protection from intruders. This minischool is the home of the Transitional Classes Program unit which occupies three of twelve classrooms; others are used for retarded children. These are large, exceptionally attractive, and cheerful rooms. Two of the rooms are arranged as classrooms with areas for individual study, small group activities, exploratory activities, library, reading corner with small rugs on the floor. The third room is multipurpose, used for lunch, art, music, recreation, discussion groups, and a variety of other activities. The rooms are decorated with paintings, interesting and colorful displays of children's work, furniture which can be moved and rearranged as needed. There is a supply of audiovisual equipment and a wide selection of teaching materials. The unexpectedness of these rooms is striking as is the sense of order which contrasts startingly with the external surroundings. Children appear actively engaged in a variety of tasks. There is movement of individuals and small groups from one room to another but obviously this is according to plan. The daily schedule on the

chalkboard outlines the general structure of the day. This is expressive of the organization implicit in this operation; a highly individualized program for each child is fit into a framework of group activity which maintains a school atmosphere. Since the goal of the program is to prepare the child for re-involvement in the general school, the class is given a school-orientation which still allows for the individual's tolerances and specific needs.

There is a basic pattern of two classes, one of 7 and one of 8 children. The staff includes three teachers and two educational assistants. This staff is augmented by the part-time services of a guidance counselor and an attendance teacher. The clinical support team, from Jacobi Hospital, includes a psychiatrist, psychiatric social worker and psychologist. The weekly full team meeting also includes district personnel - the coordinator of guidance and the supervisor of the school district child guidance unit. It is attended by the coordinator of supervisor of the program.

The school day for the children starts at 8:40 AM and ends at 2:00 PM. The children and teachers lunch together. The day is organized in half-hour segments. The academic curriculum reflects general educational content and the morning is devoted to language arts, mathematics, social studies - interspersed with snack time, gym, and lunch. After lunch there is a daily discussion group followed by selected special activities such as expressive arts, science experiments, cooking, etc. Trips are planned as are many special highlight events.

Each child has an individual daily contract which he receives at the

start of the day. This specifies his tasks and goals, both academic and behavioral, for the day. The contract reflects the long-term plan of remediation and behavioral development which has been agreed upon by the team. It translates this plan into classroom terms and activities and is based upon an educational and psychological diagnostic evaluation. Each half-hour period allows for a few minutes alone with an adult at the start to clarify any questions about how to proceed, and a few minutes at the end of the period for evaluation of his achievement. The child is encouraged to work on his own as much as possible. The overall thrust is toward developing school-appropriate behaviors and the child earns points for beginning work promptly, maintaining himself on task without interfering with others, completing the task; generally for respecting himself and the rights of others. Particular behaviors are specified for each child depending on the treatment plan. The child's points may be applied toward small concrete reinforcers or toward time to participate in special activities. The class rules are clear and simple, and essentially are protective to the individual children and to the group. The staff has discussed these rules with the children frequently and there is no question about what the rules are. The child carries the responsibility for following class rules; if he breaks them he is also responsible for the consequences.

DESCRIPTION OF CHILDREN AND THEIR FAMILIES

During the academic year under discussion our unit had 15 children divided between two classes. The children ranged in age from 9 to 13. There

were 2 girls and 13 boys. The reasons for referral to our unit were varied. Although originally the unit was set up to receive children who were coming out of psychiatric hospitals or out of residential treatment centers, since we were just starting up and did not have a waiting list of such children, we accepted referrals from other parts of the community. Our class composition was in this way significantly different from other centers within the program in that only a minority of our children--5 out of 15--came directly from institutions. (The usual arrangement was for 2/3 of the children to come from hospitals, etc. and 1/3 from the local school district--this 1/3 providing some incentive to the district for housing the program in one of their schools. Since our unit related to a small child psychiatry ward in a general hospital, our rate of discharge for eligible children was too slow to allow for more than than the few initially in the program. Rather than hold up the program for the months it would have taken to discharge enough children, we opened the enrollment to all children in the community who were unable to adjust to whatever schooling the Board of Education had to offer them. Interestingly enough, the level of pathology in the non-hospital children was of the same order as that of the hospital group, and our unit seemed comparable to the units in which 2/3 of the students came from institutions.) The fact that most of the children in our particular unit did not come from hospitals, were in no therapeutic program, and were not in treatment throughout the school year being reported, inadvertently gave us the opportunity to see what this special program alone would do for these very disturbed children.

Two clinical vignettes will illustrate the range of pathology of our youngsters. Billy was 11 when admitted to Transitional Classes Program. Prior to admission he had been on home instruction for 3 years. He was originally expelled from school because of extreme rebelliousness and fighting with peers. He was hypervigilant, afraid of any sudden or loud noise and had the conviction that people were staring at him and that someone thought he was crazy. His mother had refused referral for psychiatric treatment for him. She was very seclusive and never left him out of her sight either at home or on the street. The only plan she would ever consider was his returning to his neighborhood school. It was fortuitous that he lived near the Transitional Classes Program so that his mother accepted this referral but she insisted upon walking him to and from school each day. Psychological testing of the child revealed findings consistent with the diagnosis of paranoid schizophrenia. In addition he had no elementary mathematics skills and read on a primer level. His initial adjustment to the class was to be alternatingly ingratiating, eager to please, trying to buy friendship, while at other times becoming withdrawn and distracted, and having violent outbursts of anger at his peers.

Another child, Murray, was 11 when he entered our program after having spent two years in a residential treatment center. He was originally referred to that center because he was violent both at home and at school, he set fires, he frequently shouted obscenities and pantomimed sexual behavior with exaggerated bizarre movements of his body. His mother was an aggressive woman who felt there was nothing wrong with her child and

that his troubles were entirely imposed upon him by his teachers and society in general. In the residential treatment center where he spent two years, he was described as violent and bizarre, never making any attachment to any adult. He made some academic gains but his basic behavior and personality remained unchanged. Upon entering our school he impressed the staff as being calculatingly hostile and even sadistic toward the other children. He always found a way to tear them down and would laugh at their every discomfort. We wondered whether he would be able to develop any positive feelings toward any of our teachers and whether he would last in our program.

Turning to the family structure of our children, one lived in a foster home and the rest lived with at least one parent. Only three of the children lived with both their natural parents. The children themselves were all chronically disturbed with histories going back for at least several years. They all had severe learning problems, with total academic achievements ranging from a pre-primer level to second grade work. They all presented behavior problems ranging from moderate to severe intensity. Two of the children were diagnosed as being overtly psychotic with paranoid and bizarre behavior. Twelve of the children would fall into a borderline category with a combination of severe behavior problems, poor social relations, severe compromises with their intellectual functioning and outbursts of bizarre behavior. One youngster was diagnosed as severely neurotic. Even our most intact children had the potential for severe decompensation. For example, Allen who is 10 years old was considered to have one of the best living arrangements. He lives with both his natural parents, has a father

who is a steady worker and a mother who is very involved in his care. Allen was referred because of a severe school phobia which had interfered with his school attendance for several years and because of chronic encopresis. In his relations with other children and the teachers he was generally sarcastic, aloof and somewhat infantile. There was nothing overtly bizarre about him. However, during the summer while away at camp in an outburst of rage he demolished a piano. The intelligence of the children all seem to be within the normal range. On testing the scores ranged between 78 and 100, though it was our impression that these youngsters had some potential for better intellectual functioning than was demonstrated by testing.

As can be gathered from the above descriptions, the home situation of these youngsters was generally dismal. Of the 15 children at least 7 were considered serious candidates for placement outside the home and in fact by the end of the year one youngster had been placed in a residential treatment center while another went to live with an aunt. In addition to these 7 in which placement was being seriously considered, there were at least two other children in which placement away from the home, while not an immediate concern, was at times entertained. Three of the mothers had well-documented overt psychoses. In addition, two mothers were felt to be most probably psychotic by our screening teams and one youngster had been abandoned by his parents early in life.

DESCRIPTION OF RESULTS

One of the most striking results of this program became apparent within a fairly short time, perhaps one to two months after the program got

into full swing. This result, was simply that these children were coming to school regularly and functioning as members of a class. Throughout the entire year our attendance rate was excellent, averaging 85% attendance. This was in large part due to the diligence of our attendance teacher, who would follow up on each lapse of school attendance by either telephoning or going to the home to find out what was keeping the child out of school. The attendance teacher became intimately acquainted with most if not all of our families and had an important positive relationship with a number of the parents. He could urge a child to get dressed and leave the security of his home. He could mediate between angry mother and a frustrated bus driver. He could put into perspective some of the complaints of our youngsters about other children on the bus.

This program was evaluated during 1972-73, as is required for Title I funded projects. In the academic year being described, the Transitional Classes Program served 131 children, not including the 101 children who received intensive screening and were referred elsewhere. Of the 131 children 52% came from hospitals, 10% from residential treatment centers, and 38% from the community school districts. During that year, 31 children left the program--8 going to regular classes, 9 to special classes, 11 being rehospitalized and 2 awaited placement. the 11% return to the hospitals (100 child-years) should be compared to the expected return of 30% during that time, if the program had not existed.* Evaluation results included analysis of academic achievement. In addition to marked behavioral

* Estimated by New York State Department of Mental Hygiene--informal report.

changes it was found that 67% of the students in the program achieved a gain of two months or more in reading for every month in the program; 54% of the students achieved a two months per month gain in mathematics. The entry scores in reading for the children in the Transitional Class unit here described ranged from complete non-reader to 1.6. At the end of the school year the reading scores ranged from 1.7 to 3.6. These children had entry scores in mathematics ranging from 1.0 to 3.5. At the end of the school year the math scores ranged from 3.0 to 5.0. Teacher observation and informal assessment confirmed real gains in skills and in attitude toward academic work. Children became increasingly task-directed and showed growth in ability to organize themselves and to attend to activities. The high level of growth indicated by these results is especially interesting since test data showed some of the pupils were of borderline intelligence. The generally sought goal for "normal" classes is a gain in achievement of one month for each month in school. The program results were markedly better, leading the evaluators to conclude that the teachers had developed a high degree of excellence in programming for academic remediation. We believe these results also were influenced by relational factors implicit in the entire climate of the program.

These statistics do not, of course, tell the story of how so many of the children for the first time felt that they could produce and achieve something meaningful with adults and in a school setting. During one group discussion session Billy was complaining that his mother never allowed him to go on trips with the other children. Others in the group asked him how

he responded to this. He replied that he did nothing. He was urged by the group to point out to his mother how responsible the teachers and staff have been and how safe the arrangements actually were. He could also point out his own increasing ability to control himself. Billy followed through and to the amazement of himself and the entire staff from that point on his mother permitted him to take the trips. Warm personal contacts between staff and children are difficult to describe but permeated the work.

An interesting finding about the children's academic achievement was that as the year progressed and the teachers became more intimately acquainted with the children, it became clear that they had entered our program with a scattered collection of partial skills--some phonetics here, some arithmetic facts there--and that as they became more confident and relaxed they were able to integrate material much of which had been known to them in bits and pieces. This seemed to partially explain their good academic progress.

While during the first year we did not lose a single child in the Jacobi unit--the one girl who went to a residential treatment center was originally accepted with this goal in mind--during our second year, some of our limitations became more apparent. Some of the children who used the school as the major organizing influence in their life to be involved in minor yet ominous for the future delinquent behavior outside of school. One child became so rebellious and received so little help at home that child protective services had to be contacted. The results of this move are

still in doubt. Another youngster, on the verge of leaving our program for a special school placement suddenly stopped attending school and began coming home only after midnight when his mother returned from her evening shift job. He recently required subsequent hospitalization in order to better understand what was happening to him.

The close working together of mental health professionals with educators allowed us to screen difficult children into the program rather than out. We have had to take a very progmatic attitude toward the ultimate value of what we are doing. Time alone will tell, but only if we persist in our efforts and in further evaluations. In the meanwhile it is our conviction that we are offering a valuable school experience to significant numbers of children in their communities--where in the long run they must live and develop.